THE INDUSTRIAL COMMISSION OF ARIZONA

MEDICAL RESOURCE OFFICE

REPORTER'S TRANSCRIPT OF PROCEEDINGS:

Public Hearing on Laws 2018, Chapter 101,

Section 3 (Senate Bill 1111)

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Phoenix, Arizona
August 23, 2018

P R O C E E D I N G S

CHAIRMAN SCHULTZ: I would like to call this meeting of the Industrial Commission to order, and I would like to start with the pledge of allegiance, please.

(Whereupon, a brief pause was had.)

CHAIRMAN SCHULTZ: I'm Dale Schultz, and I'm Chairman of the Commission; and I would like to have -- introduce everyone else at the table here. James.

MR. ASHLEY: James Ashley, Director.

MR. HENNELLY: Joe Hennelly, Commissioner.

MR. KRENZEL: Steve Krenzel, Commissioner.

MR. PORTER: Jason Porter, Deputy Director.

MR. TESTINI: Gaetano Testini, Chief Legal Counsel.

CHAIRMAN SCHULTZ: And on the phone we have.

(Inaudible.)

CHAIRMAN SCHULTZ: Mr. LeMarr, are you there?

MR. LEMARR: Yes, I'm here.

CHAIRMAN SCHULTZ: Thank you. Very good. We also have a couple of call-in attendees that have joined us, and could you please introduce yourselves.

Kevin? He may not have joined us.

Alan? Okay. He may not have joined us.

So, good afternoon. Welcome to this public hearing regarding medications dispensed in settings that are not accessible to the general public.

By way of summary, earlier this year Arizona lawmakers passed Senate Bill 1111. Section 3 of Senate Bill 1111 stated: On or before July 1st, 2019, as a part of the Industrial Commission of Arizona's Annual Review of the Schedule of Fees pursuant to Section 23-908 A.R.S. as amended by this act, the Industrial Commission shall review information and data; consult with physician, employee, business and industry stakeholders and hold at least one public hearing in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public.

In addition, A.R.S. 23-908 was amended to give the Commission authority to include reimbursement guidelines in the Arizona Physician's and Pharmaceutical Fee Schedule for medications that are dispensed in settings that are not accessible to the general public.

Following the passage of Senate Bill 1111, the Commission began reviewing information and data regarding the dispensing of medications in settings that are not accessible to the general public.

The Commission retained PCG Health, a leading public sector consulting and operations improvement firm, that partners with governmental health agencies to review available information and data related to the topic of physician dispensing and to prepare a white paper that summarizes relevant issues and practices in other states. The white paper was publicly posted to the Medical Resource office web page in advance of this public hearing.

In addition to efforts to review relevant information and data, the Commission has consulted with the various stakeholders in an effort to better understand the issues.

We now welcome you to present your oral comments regarding the issues of medications dispensed in settings that are not accessible to the general public.

Those wishing to speak may do so by filling out a speaker slip, which is available both inside the door and outside the door. I will call each speaker who will have five minutes to speak.

Please note that at this time the Commission has not made any decisions and is not proposing any particular reimbursement guidelines related to medications dispensed in settings that are not accessible to the general public.

Although the public hearing will end when oral comments have concluded, written comments will be accepted through close of business on September 13th, 2018 -- important date -- September 13, 2018.

Once the record is closed, the Medical Resource office will carefully consider all public comments and available information and data and will prepare -- propose reimbursement guidelines in conjunction with the process of updating the Arizona Physicians and Pharmaceutical Fee Schedule. These proposals will be publicly posted, and the Commission will schedule another public hearing to receive additional comments.

With that, we now open the floor to public comment; and we will begin with a presentation from our consultants, PCG, on the issues.

By the way, all comments -- both made here and written comments -- will be posted to the website and available for everyone to see. Go ahead.

MR. JONES: Good afternoon, Commission, and good afternoon, Everyone. Thank you for attending. Again, my name is Coy Jones. I'm with Public Consulting Group, and my colleague, Nile Kazimer and I, will be going over some of our findings from reviewing work in other states around physician dispensing.

The -- as Chairman Schultz mentioned, this

is part of an ongoing effort to look at the issues around physician dispensing as well as work we have been doing with the Commission around reimbursement and fee schedule regulation and to see what role the fee schedule and reimbursement might have on this issue.

Today we want to present some of the issues that we have seen in physician dispensing generally as well as, you know, specific to the workers' compensation space and any kind of evolving set of best practices, both generally and in relation to workers' compensation in particular.

So, again, I'm just very quickly going to go over the overview and objectives that Chairman Schultz mentioned. Talk about the facts a little bit, very high level background of what is involved in physician dispensing, and then Nile will go into the specifics around workers' compensation, cost concerns, and perceived public health impacts. And then -- then I believe there will be some additional presentations.

So overview and objectives. Again, this is a part of the legislative mandate to pursue and consider potential reimbursement guidelines; and we have really been tasked in three different aspects of our white paper. One is to just present the issues that have emerged in physician dispensing -- both pros and cons -- to try to

develop a comprehensive picture of what is at stake in this issue, health implications as well as issues around cost containment.

Another piece of our scope has been to provide a detailed analysis on the impacts of State reforms. So Arizona is not the first to tackle this issue, and it will not be the last state. In workers' compensation system there have been a number of states that have -- where this issue has been raised in various attempts to regulate physician dispensing. So, you know, we have done intrastate comparisons, pre and post reform, what was done, what has happened as a result, as well as comparisons among states that have addressed this issue in some ways and states that have not addressed it and the outcomes in those different places.

The third part of our white paper, which we have not done yet, is to develop policy recommendations and options based on our understanding of what the industry looks like and other state efforts, what is most applicable to Arizona, what is in the best interest of the system. So as a piece of that, we are rounding up our best practices. We are rounding up the lessons learned from other states, and we are taking in feedback from public hearing. So we -- when we do that third part of our white paper, you know, we intend to incorporate the

feedback both in support of the position of dispensing practices and also those stakeholders who have raised concerns about at least certain aspects of physician dispensing and generate some findings and recommendations based on all those kind of sources of data.

Again, reiterating that we are not there yet. So we are presenting the issues as we seen them in the best practices. Make it very clear what we are looking at, and we very much value your feedback and -- in terms of identifying what is not at issue for Arizona, what is an issue for Arizona; and we do hope to incorporate that in our final white paper.

So what are we doing here today? Other than presenting, we are receiving input and information concerning the issues of physician dispensing. Again, reminding you that September 13th is a very important date to get written and oral comments on the issue in, and then the plan -- the plan as we understand it is the action taken by ICA will be proposed in the 2019/2020 fee schedule staff proposal recommendations document, and the plans are to be posted in April of 2019. I believe there will be some additional opportunities to provide comment as the process evolves.

Just to give you an overview of physician dispensing -- not necessarily in workers' compensation

alone -- but an overview and orientation of the issue in general. It is the practice in which clinicians dispense medications directly to patients out of their offices; and as part of the service, physicians earn some revenue from prescribed -- prescribing medications inhouse. So this is a practice that is permitted in Arizona provided that the dispensing physician registers with the Arizona Medical Board. There are certain regulatory requirements around disclosure, storage, data entry, labeling rules; and then physician dispensing is one of those practices of self-referral that is exempted from Stark Law.

Why is this an issue? What is at stake here? Why does it come before the attention of the Commission and Legislature? Well, in general -- not just in workers' compensation -- but in other areas of the healthcare sector, it has become a major contributor to increasing prescription drug costs, particularly in workers' compensation.

In workers' compensation physician dispensing can account for over 60 to 300% of the increase in prices paid for commonly prescribed medications in comparison to retail pharmacies. The practices have raised concerns about adverse drug events, surveillance as well as opioids use. As you all know most likely, this is a part of a broader set of initiatives undertaken by the

State to deal not only with the cost containment issue but with opioid use and other forms of drug surveillance.

So in terms of how the -- there are a number of different camps on physician dispensing. Many in favor. Many in opposition. What we have done in our white paper is sort of roundup some of those pros and cons. Again, not necessarily coming to any conclusions on which of these are legitimate and illegitimate arguments; but putting things out in terms of a roundup of arguments, these are the sorts of arguments that are generally put forward in support of a particular position.

I will go through the proponent arguments first. Again, this is not necessarily specific to workers' compensation. First, is physician dispensing ensures or helps to ensure medication initiation, adherence and compliance. It's really kind of closer to the treatment and being connected with the physician, which helps to ensure medication adherence in particular.

The point -- it's also suggested the point of care access to medications will reduce some of the geographic barriers in remote areas. It supports -- it is yet another avenue for access to medications and supports access to care in general.

Another argument put forward is the ability to obtain medications at the point of care increases

patient satisfaction, and that there is an overall reduction in overhead costs, in reduced need to communicate with pharmacies. So there is some care/coordination issues that are represented. Then a reduced likelihood of communication errors due to decreased need to relay information to pharmacies; and finally, it is seen as a vital source of extra revenue.

Now, on the side of opposition, many people claim that overpriced medications -- that they become overpriced when they are dispensed by physicians rather than pharmacies, and that those drive prescription costs. That there is an increased likelihood that over-the-counter medications will be prescribed at a higher cost under physician dispensing, and that it circumvents public health surveillance systems that rely on centralization and prescription data. And then, finally, the physician dispensing undermines the mechanisms designed to identify drug safety issues, narcotics abuse, abuse of diversion and duplicate therapies.

So that's really kind of a landscape overall. Workers' compensation is a very unique space in the healthcare sector. I'm going to turn it over to Nile to kind of talk about what are the real salient issues in this particular industry.

MS. KAZIMER: Good afternoon. My name is Nile Kazimer. I'm a consultant with the Public Consulting Group. Today I will go over the issues specifically under the lens of workers' compensation, the implications that the practice have on the cost in this area in particular; and I will be citing several statistics and findings from the WCRI and the NCCI.

So with regards to the physician dispensing and workers' compensation, one of the biggest topics that has been raised in numerous studies is this use of financial incentives versus medical necessities. As far as research by the WCRI, the Workers' Compensation Institute, from 2007 to 2011, they looked at prescription data nationwide. I believe they included 20 states in their analysis, and they found that there was a rapid growth in physician dispensed pharmaceuticals under workers' compensation; and that the prices of physician dispensed medications are much higher than that of pharmacies and that in 13 of the 20 states that they have examined, 1 in 6 prescriptions were physician dispensed. And in the states listed there -- California, Florida, Illinois, Georgia and Maryland and Arizona -- that is 1 in 3. That is more recent data from 2010 to 2011.

And among states where physician dispensing was common, there was a higher percentage of injured

workers being prescribed medications that are rarely dispensed in states where this practice is less common. Common drugs prescribed under workers' compensation are targeted for reformulations that are higher priced and able to bypass numerous pricing regulations that are based on original formulations of that drug.

Now, what this shows is that the pricing regulations that have been in place that deem that physician dispensing have been shown to alter prescribing patterns, particularly in workers' compensation, and that the practice is prone to perhaps monetary influence rather than medical necessity alone because we do see that in states where physician dispensing is less common. Certain types of drugs are dispensed at a reduced rate, at a rate that is statistically significant and different.

As far as diving into some of the specific proponent points that Coy raised about the four camps for physician dispensing, one of the main arguments was that the practice allows for access to medications at the point of care right when patients are there with their doctors. That is true and that has merits in so many ways.

However, there has been absolutely no research that we found up-to-date that specifically quantifies the health outcomes that have come with that in a positive light. There is -- there is also this idea

that physician dispensing in workers' compensation allows injured workers to bypass some of the very complex and existing bureaucracy issues when it comes to obtaining medications, and that is true. However, there is also no research so far to quantify this section of this issue. What does that mean? That means there has been no research that shows exactly how long is this delay and what is the impact of this bureaucratic delay and what impact that has on health outcomes.

To date, there has been two studies that actually have shown that physician dispensing in certain medications that are prescribed under physician dispensing actually has adverse health outcomes, implications; and we will go over that here in a few minutes.

The second issue that is raised by proponents of physician dispensing includes this idea that the practice allows initiation and adherence. Physician dispensing has -- does provide medications at the point of care. However, peer-reviewed research on this topic reveals wide variations in initiation and adherence rate and depends on the kinds of medications that are prescribed at the point of care.

For workers' compensation, the bulk of the medications that are prescribed under the program are pain medications. When we looked at data that pertains

specifically to pain medications, we found that adherence to pain meds is much less of an issue than compared to, say, adherence to diabetes management medications or cardiovascular health management medications.

Research on medication adherence also is often focused on maintenance medications rather than for chronic diseases, rather than acute work-related diseases. Adherence can also refer to a variety of things; that is, underuse, overuse or misuse of the medications altogether. So in order to better explore this topic, we need to further define what we are looking at. Are we looking at underuse of medications, overuse, or use of medications for instances that it was not prescribed? Most prescriptions in workers' compensation, like I said, are for pain medications; and therefore, compliance has been shown to be less of a concern.

Now, we will go into cost concerns. For this, I would first like to introduce this idea of repackaging. Repackaging has been attributed to be the major cost driver in prescription costs under physician dispensing due to this idea that the medication is removed from its original container and put into new containers with higher prices. Basically, the drug itself has not changed but the price tag has in the process. And until recent reforms, repackaging was a significant cost driver

because a new national drug code, a new NDC, was given to these repackaged medications, which does not appear on existing fee schedules which allow for higher reimbursement rates.

Another area of concern is unmanaged prescriptions, which physician dispensing falls under. They refer to prescriptions that are prescribed outside of your traditional mail-in order pharmacies or retail pharmacy networks. There is a disproportionate amount of unmanaged prescriptions within workers' compensation making the system more fiscally vulnerable for the following reasons: The first is that physician dispensing bypasses the traditional cost and inventory control applied by networks that make up pharmacy benefits before prescriptions are dispensed. These are usually negotiated rates that are not inherent in physician dispensing today.

Physician dispensing as a practice does not employ rigorous formulary enforcement, thus decreasing the generic efficiency, which can be a significant cost driver. Generic deficiency here refers to the proportion of overall prescribed medications that are the generic equivalence of a brand counterpart. So how efficiently is the system able to pick a generic medication over a branded version that is often times at a much higher cost? And basically the point is saying that under physician

dispensing, branded version is the go-to option.

Physician dispensing does not allow for the necessary data sharing systems in which pharmacies have in place to track real-time data associated with various injured worker populations. This has wide ranging implications in utilization costs as well as health outcomes, and we will go over this in detail in a few slides.

I have a few examples here from the WCRI. This is from their 2010 to 2011 data. It specifically pertains to the medication Vicodin and Mobic. For Vicodin, they found that average price per pill under physician dispensing nationwide was 100 to 300 times higher than the price paid for the same medications by pharmacies.

When California and Georgia implemented pricing reforms targeted at this markup, they found that that dropped to about 19% and 67% respectively. For Mobic, the average price per pill paid per physician dispensed medication was 40 to 220 times higher than that of the same drug dispensed by pharmacies. There is a lack of medical evidence here as well that suggests that Mobic is more effective than ibuprofen which is a much cheaper counterpart.

Furthermore, the rapid growth of Mobic

prescription coming from physician offices in the states where physician dispensing is common, such as Illinois, they found that 80% of all meloxicam prescribed in that state were dispensed by physician; and this is this figure of 80% or above and is not found in states where physician dispensing is less of a common practice.

Here is case study as well. We picked out this one given the implications that it has both on pricing itself and on public health concerns. So among states where physician dispensing is common prior to reforms -- in Florida, Georgia, Illinois and Maryland -- 8 to 11% of injured workers were prescribed omeprazole or Zantac or both. The average price per pill paid under physician dispensing in these states were as much as twice higher than prices paid for -- in states where physician dispensing is less common, and these two medications are rarely prescribed in states where physician dispensing was less common.

And now we will move onto the public health impacts and implications of physician dispensing. So we have looked at peer review research on this. We ventured out into research surrounding healthcare IT and interoperative issues and the idea of dataflow, and we found that physician dispensing have public health implications particularly when it comes to drug

surveillance. So with the practice at its current state and where we are today with our health IT systems, it really prohibits rigorous public health surveillance and monitoring of medication usage and drug interactions.

In physician offices data is still often siloed and data sharing is still incredibly hard to occur; and numerous research that shows nationwide this remains an issue today even with the implementation of the electronic health records.

Pharmacies are better able to provide medication oversight and utilization reviews given their one-to-many relationships they have with multiple providers feeding in this information to a centralized data system that gives them the greater visibility to see across multiple physicians and across multiple practices for that same patient.

Prescription centralization entities, like I said, they are able to track and look at population health level data; and they are able to respond in a more real-time manner relying less on data feedback from these silo systems.

With opioids, the National Council on Compensation Insurance, NCCI, have conducted research on this and have found that for opioids such as Oxycontin, Oxycodone and Acetaminophen they were among the most

widely prescribed drugs in workers' compensation as recent at 2014.

During that same year, data from the WCRI shows that physician dispensed drugs and controlled substances grew faster than any other category of prescription drugs. In 2018 WCRI released a report earlier this year that actually showed excessive opioid prescription led to longer duration of temporary disability benefit claims.

Certain states have prohibited physician dispensed opioids altogether; that being Florida where Schedule 2 substances are now completely banned for physician dispensing, and physician dispensing has been shown to encourage opioid prescriptions in numerous studies by the NCCI and the WCRI.

Now, that we set up the issues we can dissect as far as cost concerns and public health concerns, we will move into what have states done to address this issue, the regulatory approaches that have been taken and the lessons that have been learned. This is by no means a comprehensive list. These are the major sort of targets that states have used to address the issues of physician dispensing.

The first tool that employed pricing reforms and regulations -- one of which Arizona has

already adopted parts of it -- requiring parity in fee schedules between pharmacies and physician dispensaries, often determined by the average wholesale price -- Arizona currently requires that the average wholesale price of the original manufacturer's drug is used rather than any repackaging at original wholesale price.

The second part is require that medications be billed under the original national drug code and not the new national drug code that may have been obtained under repackaging, and the third is limit or prohibit of the dispensing fee altogether. Currently Arizona charges -- allows for a $7 dispensing fee.

The second means has been licensing and reporting requirements, so the use of medical boards and boards of pharmacies. Arizona currently requires that physician dispensed entities register with the Arizona Medical Board; that registration and licensing requirement also is with the DEA for narcotics dispensaries.

The third main approach has been to regulation, regulate supply and dosages, how much of a medication is allowed and for how long. Prohibition and restrictions on medications that are susceptible for abuse has been particularly targeted under this option. The main ones that have we have been seen has been restriction on dosage and supply.

The last one is restriction on credentials of those allowed to dispense medications, and this pertains to physician assistants, nurse practitioners, limiting the scope at which they can make that determination and dispense medications.

And to further continue exploring regulatory approaches in this space, states with the strictest physician dispensing regulations include but are not limited to the states listed there.

Utah only allows physicians to dispense certain drugs at employer-sponsored clinics. They took the most restrictive approach to allowing this practice. Texas only permits dispensing to meet patients' immediate needs in rural areas. They keep the access or benefits for patients here but haven't taken a very restrictive approach otherwise. Massachusetts only permits dispensation of drug samples. Florida prohibits physicians from dispensing 2 and 3 controlled substances in all instances, and California has reforms that require preauthorization of certain drugs under their established medication and also includes regular enforcement of a formulary that they are very strict about.

So we picked two states that have done the most work in their reforms targeting physician dispensing, and that is California and Florida. California began a

series of reforms starting in 2007 which required that fee schedules for physician dispensed drugs be based on the original manufacturer's NDC. That was their first step to addressing this issue. Arizona has also adopted this policy in recent years, and the key findings from their initial reforms to now are as follows:

First, is that price reduction did not result in lower prescription. This suggests that patients' access to medications were not interrupted.

Second is that less prepackaged drugs were dispensed cheaper and non-repackaged drugs were dispensed instead. There was also a decrease in frequencies of prescription drugs associated with higher than usual consumer prices under physician dispensing. In instances where physicians stopped dispensing in response to that price reduction and price control, pharmacies were able to compensate and do so at a lower price.

Florida Senate Bill 662 required that all prepackaged medications dispensed at physicians' offices be reimbursed at 112.5% of the average wholesale price as determined by the original manufacturer's NDC. The reform had little impact on the number of dispensing physician practicing dispensing but caused a decline in the number of prescriptions instead.

The key finding from Florida reforms are as

follows: The first is that prices of common physician dispensed drugs declined by 19 to 41% even though prices paid to pharmacies during that period remained constant or increased. Cost savings were, however, off-set by introductions of new strength products at higher prices. So what does this mean? It meant that 4 of the top 10 of the most frequently dispensed drugs, which made up 16% of the total physician dispensed medications, saw that 19 to 41% decline in price. However, that reduction was off-set by a 63 to 66% increase in prices of two medications that make up 24% of the total medications prescribed. So they achieved cost savings due to pricing restrictions, but that was off-set by these two medications that make up the bulk of the total prescription.

The 112.5% of AWP, allowance that they put forth, plus an $8 dispensing fee for reform, may have actually contributed to pricing increase in several of the medications prior to the reform had prices that were lower than 112.5%. So they were kicking the prices up to meet that 112.5% threshold.

Specifically for Arizona, Arizona clinics that dispensed medication at the point of care to workers' compensation patients are currently reimbursed on calculations using the workers' compensation average wholesale price based on the original manufacturer's AWP.

This has been somewhat circumvented by newer strength formularies or different dosages that has a higher original manufacturer's AWP. So much of this first point has been off-set as well. The reimbursement schedule for physician dispensing to workers' compensation patients is 85% of the manufacturer's AWP plus a $7 dispensing fee allowed. Medications here also include prepackaged dispensable injection kits as well as compound topical creams, which has been shown to have one of the highest growth rates of prices currently.

Furthermore, I would like to point out the steps that have been taken this year and the regulations that have been passed in the State of Arizona to specifically address the issue of opioids abuse and combat the opioid epidemic.

First is SB 1001 that was passed in 2018, earlier this year. This one -- for SB 1001 there was a limit in initial prescriptions for Schedule 2 opioids to a 5-day supply or 14-day supply when it was related to surgery. There are a few exceptions on that as well. A prescriber may not issue a prescription for Schedule 2 opioids which exceeds 90MGs per day with exceptions as well. It requires the dispenser to obtain a utilization report from the State's prescription drug monitoring program prior to dispensing a Schedule 2 controlled

substance, and all prescriptions must use electronic prescription systems by 2019.

That last point particularly highlights where we are today with regards to these systems, and the full implementation of the systems has yet been realized.

With SB 1111 that was passed in April of 2018, it applies prescribing restrictions for doctors who are providing opioid/analgesic treatment specifically to injured workers. The applied provisions of SB 1001 to all opioid and incorporation of language directly into workers' compensation law. The bill enhances reporting requirements and patient requirements that a provider must provide in order to prescribe controlled substances. It further requires prescribers to obtain patient utilization report from the Prescription Drug Monitor Program, PDMP, at least quarterly while treatment is ongoing and before prescribing opioids or benzodiazapine, Schedule 2 substances. It also includes a key definition as newly required in treatment reports mentioned above and a new definition of what is considered traumatic injuries.

So the State of Arizona has very recently implemented very rigorous reforms targeting specifically opioids; however, much of the reform leaves out other kinds of medications that are also very common in workers' compensation; and that's what we are here to discuss.

That's it from us. I will be able to take comments at the very end.

CHAIRMAN SCHULTZ: Please. Thank you Coy and Nile. If you do have questions or comments from this presentation or any of the other speakers, please hold them to the end. We will give you an opportunity, but that will help us eliminate cumulative questions. So thank you for that.

Now we will have our next speaker, Gale Vogler. When you come to the podium if you would please introduce yourself, state your name and who you are representing.

MR. VOGLER: Good afternoon. I'm Gale Vogler. I'm with CopperPoint Insurance. I'm the director of medical management at CopperPoint. I appreciate everybody's time today; letting us come and speak on our position regarding physician dispensing in Arizona.

CopperPoint urges the Commission to adopt the reimbursement guidelines outlined in 2019/2020 Arizona Physician and Pharmaceutical Fee Schedule. I'm going to show some data on these slides that is pertinent to Arizona. These are derived from our actual workers' compensation claims handled at CopperPoint.

Our data shows in Arizona there is a very small number of medical providers who are engaged in the

dispensing, and they drive tremendous profits at the expense of the injured workers, their employers and the workers' compensation system as a whole.

The data I'm showing is from July 15, 2017, through July 15, 2018. During that time CopperPoint paid 29 different physician dispensers for medications costing a total of $2,194,437. And as you can see from the slide up here, the top three dispensers were responsible for over $1.9 million worth of that spend.

This slide will show the breakdown of those 29 different prescribers. Significantly only 5 of the 29 dispensers were responsible for 95% of all the dispensing costs.

Physician dispensing is not more convenient to the injured worker especially after the first fill situation. Physician dispensed refills require the injured worker to attend another doctor visit typically during business hours and/or on weekdays. By contrast pharmacies available to the general public are often available a lot of different hours. Some have 24/7 access but definitely available before and after regular business hours.

Some say that the physician dispensing allows the injured employee to get their medications more efficiently. We found the majority of CopperPoint injured

workers reside in areas with access to multiple pharmacies within a short distance. In fact, most had upwards of 50 or more pharmacies within a 15-mile distance while others in rural areas had at least 5 pharmacies in that range.

Most carriers also have the, what we call, pharmacy benefit managers. Most of those pharmacy benefit managers also offer mail order; pharmacy services that deliver typically a 3-month supply of medications directly to that injured workers' door.

I will show a couple slides on the cost that we see from physician dispensing for medications versus non-physician medications. Duloxetine, 30-milligram capsules -- as you can see on the slide -- during that time period, CopperPoint spent $189,970 on this specific drug through physician dispensing. With that same amount of volume of drug through a retail pharmacy, CopperPoint would have only spent $3,596 on that same medication. You can see there is a large financial incentive in physician dispensing.

I have a couple other data points on a couple different types of drugs. We see on this physician dispensing we saw a charge for $3,327 for a specifically formulated Menthoderm Ointment when compared to a typical muscle rub product that an injured worker can get over the counter, that same product over the counter was $52.61.

Obviously we are going back to this Duloxetine per pill charge for special formulation of this is about $7.54 when physician dispensed. Typically through a PBM we can get that same prescription at $0.20 a pill.

I will show a couple slides of what we see is our average cost of claim. With physician dispensing our average cost of claim -- this is medical and indemnity cost -- $4,280; and when physician dispensing is not involved, that same claim will be $2,370.

Average cost per scrip -- physician dispensed versus pharmacy dispensed -- physician dispensed per scrip of top three physician dispensers are $546. That same scrip dispensed by a retail pharmacy $221.

What are CopperPoint's recommendations in light of the concerns? We suggest the following concepts as the Commission considers optimal reimbursement guidelines for medications dispensed outside the pharmacy setting: Any reimbursement restrictions should apply not only to medications dispensed by physician in their offices but to all medications dispensed in settings not accessible to the general public.

Any reimbursements for medications dispensed in non-pharmacy settings should be limited to circumstances where all of the following apply:

Medications dispensed is not for more than an initial one-time limited supply. We feel in the realm of about 14-day supply. Medication is dispensed with short period after the injured employee seeks treatment; typically within 72 hours we feel is sufficient, and that will give them access to emergent circumstances. Medications formed to formulas and dosages customarily available in a pharmacy setting and available to the general public.

All in all CopperPoint believes that the adoption of the reimbursement guidelines is essential to the sustainable system that provides quality medical treatment to the injured employees in a safe and cost effective manner. That's all I have today. Thank you.

CHAIRMAN SCHULTZ: Thank you, Mr. Vogler, and we truly appreciate the Arizona specific data. It is very helpful. By the way, Mr. Vogler's information, as well as all other written comments received, will be posted within a very few days. Of course it takes a few days for IT to get it posted on the Medical Resource Office website. Everything we receive will be on that website. Thank you. Our next speaker, Joe Falb.

MS. FALB: Hi, Mr. Chairman and Members of the Committee, thanks for allowing us to speak today. My name is Jill Falb, and I manage pharmacy benefits for CorVel Corporation. CorVel is a national provider of workers'

compensation solutions for employers, third-party administrators, insurance companies and government agencies.

At the core of our offering as a PBM manager is what we call prospective management. We firmly believe that -- it is at the core of our belief that in order to manage pharmacy benefits, they must be managed safely. So we have gone through a lot of -- I have listened, and it has been so informative about the cost concerns with physician dispensing; and while they exist, I want to focus a little bit more on the safety. I'm going to do that by talking about how we manage pharmacy benefits and the efforts that we go through with even going through traditional pharmacy methods.

So what we feel is to effectively manage workers' compensation prescriptions, it starts with a strong clinically based formulary; and we can only create that formulary with an integrated data set, with data accumulated over the years with our experience.

They also -- medication should be prospectively managed. That includes a rigorous, comprehensive point of sale, DUR edits and clinical review. So all medications need to stop at the point of sale. I will give you an example. A Claimant, an injured worker, will go to a pharmacy with a very common Z pack.

If they go to the pharmacy and present that Z pack, the pharmacist will be able to look in his data; and it will be flagged if he is taking a blood thinner. The combination of these two medications are very, very dangerous. So that -- that is an example of within the physician dispensing arena, there is no access into that information. The physician has to rely on the Claimant or the injured worker to let them know what he is taking. So this is stopped right at that point. They also screen for issues with safe dispensing including drug interaction and therapies.

So what our team does as we -- we take it a few steps further. So we have created this formulary. If a medication isn't on the formulary, it is stopped at the point of sale. Stopped. We review for safety. A phone call is made to our group. We have nationally certified pharm technicians, and they take the call and ask very important questions such as: Is this related to the work comp injury. They access our data to look to see what else has he been filling, what is his injury, what is his diagnosis code, what are the notes on file, what is known about this particular person. We arm our adjusters to make good, safe decisions. This is all before the medication is dispensed. We have access into all medications that they are taking.

Now, this workflow can't be supported with a physician dispensing model. That's a retrospective model. So they are already out the door. Now, it is so important to our team that a third of our department -- and I manage operations -- is called the unmanaged dispensing team. So their sole focus is to take medications out of network and bring them back in however they can. We leverage our agreement with our pharmacy to ensure that pharmacies are using pharmacy cards and therefore applying formularies. We apply that. We leverage our PPO agreement with prescribers. They agree to a strict utilization review program that includes: Do not dispense out of your office. It is not safe.

All of these factors are what we do; what we feel we are doing it right when we do this. Now you guys, as I said, talked about the financial impact on this and that is significant; but we feel the safety is just as significant.

I want to talk about some states that are doing it right in my opinion. We work across the country with all different states, and New York -- now, it is a combination of a directed care program -- so they have allowed their -- their PBM managers and payers to direct care and say, you need to go through the pharmacy. You need that safety net of a rigorous DUR process. That,

combined with the limited physician dispensing regulations -- limited to a first fill -- and their medical pharmacy to medical spend, which is a barometer or metric in our industry to show what a ratio is -- that pharmacy to medical spend went from 14.3% when it started in 2015 to 7.7% in 2017. That is a significant drop. So we know managed prescriptions are working and managed programs. That's all I have.

CHAIRMAN SCHULTZ: Thank you. Emily Rice.

MS. RICE: Good afternoon. I'm Emily Rice with B3 Strategies, and I'm representing the Arizona Self-Insurers Association. Our membership includes some of the largest private and public sector self-insurers in the State. On behalf of ASIA, I want to thank you, the Industrial Commission of Arizona, for your consideration of this issue and development of reimbursement guidelines for medications dispensed in settings that are not accessible to the general public such as instances of physician dispensed medications.

At the ICA's request for public comment focused on data, I will be discussing instances where our members have been able to share differences in costs and prescribing behavior related to prescriptions in a pro setting versus documented retail costs or other coverage prescribing behaviors. This data comes from a public

sector organization and as of today funded by the Arizona taxpayer.

This public self-insured saw cost differences ranging from $19.71 per prescription increase from the retail price of Tramadol HCL to $1,064.74 per prescription increase from the retail price of Topiramate, an anticonvulsive medication. From a percentage increased perspective, this insurer saw increased costs for physician dispensed medication ranging from 9% to 228% and per pill cost increases ranging from $0.30 per pill increase to a $12.17 per pill increase. In no instances did this insurer see a cost savings related to physician dispensed medications.

On average this Arizona public self-insurer saw a 67% increase in costs related to physician dispensed medications compared to retail costs within a five-month period. These increased costs reflect the prescribing behaviors of only three workers' compensation physicians and related to prescription for 12 different medications. For this insurer these doctors also prescribed well over the average number of prescriptions per physician; prescribing an average of 13 prescriptions per physician compared to a system average of 4.26 prescriptions per physician over a six-month period. While these doctors represent only 2.5% of the total number of physicians that

this self insurer works with, they represent 8% of the self-insurer's total prescriptions.

While the problems with physician dispensing is relatively small in Arizona today, the 22 other states that have addressed the physician dispensing saw the practice grow to the point of getting major workers' compensation. In Illinois and Florida more than 50% of the workers' compensations prescriptions were physician dispensed.

Based on national average, as we had mentioned, drugs dispensed by physicians are typically between 60 and 300% more expensive than those dispensed at a retail pharmacy. With prescriptions also being the largest cost for insurers, the need to control costs is critical especially for tax payer organizations.

Although our health insurer provides a small sample, it illustrates that this is an Arizona problem that has fiscal and patient consequences; that if left unaddressed, could drastically increase. The physicians that this insurer works with dispense medications prescribed approximately 30% more medications than their system average and increase the self insurers pharmacy cost by an average of 67%.

Identifying the depth and scope of this issue early can help ensure patient, insurers and identify

taxpayer protections and circumvent this issue from growing to the same magnitude by other states. Thank you for your consideration of this issue.

CHAIRMAN SCHULTZ: Next speaker, Todd Delano.

MR. DELANO: Thank you, guys. Thank, everyone, for your time. I think I can frame this -- first, I'm Todd Delano. I'm the CEO of ServRX. We are a billing firm. We represent -- we are contracted with well over 10,000 pharmacies around the country including physicians. We manage thousands of accounts, thousands of doctors. Yet 70 to 80% of our business is also traditional pharmacies including some grocery store chains you would recognize in this state. We do have a fairly comprehensive list of clients and expertise and that is in all 50 states as well although we are here in Scottsdale where our corporate headquarters are.

You guys have a lot of information to sift through; and for me to sit up here and give you too many points or counterpoints, I don't think would do you a lot of justice for my time here. I would frame this in a way of looking at a continuum of healthcare. This is workers' comp, and this is a healthcare situation we are trying to discuss and solve. You can clearly make a line down the middle, and you will hear from people on the payor/large employer side; and you will hear from people from the

provider side; and if there was an axis to me, there is a far extreme left side as well. So when you are in front of a panel sometimes, your job is to pluck certain data points. It will help you show the disparity of why your point is right and why their point is wrong. To me it does you a disservice because it is your job to sift through what are the facts, where do things lie. So I hope my job is to be a voice of reason. While I represent the provider side, and predominantly on the network, I want to be a voice of reasonableness to the panel and hopefully to you guys in the coming weeks as you decide what to do on this issue.

Let me first say that the study, the white paper that was produced today -- I think it was noted by Gale justifiably so -- and you mentioned that Arizona data is most applicable to our discussion today. I won't belabor the point, but the study was from 2011. The world looks vastly different in 2018 even in the states mentioned in the study; and specifically each state has its own fee schedule, its own ecosystem, its own payor mix; and therefore the data we should be focused on is Arizona and how it impacts our community and our state.

Just to make few points, though, because the white paper is a -- I would say a starting point for you guys as a frame of reference -- the first topic of

compensation was with the overpriced medication. I think it needs to be said. I'm not sure who understands the information that was shared about the repackaging of medication. First, let me say not an issue in Arizona to be very clear. There is probably 12 to 15 generic -- manufacturers of the majority of the generic drugs that supply to the country, and you will see their NDC and AWP -- the two acronyms you have been hearing today -- they are all compromised -- most of them within 5 to 10% of each other.

At the State level, Arizona has addressed that by saying you must go manufacturer's original AWP, number one. Number two, you specified an amount for both generic and brand. Let me state that 85% of generic original AWP state reimbursement rate in Arizona is one of the lowest in the country. You guys are being prospective. You have been reflective in how you are adopting rules and regulations in the ICA, and you are on the front side of the prospective curve.

Another of the three opponent points, if you would, in the white paper study was that physician dispensing prohibits public health surveillance. Maybe in 2011 for a large portion. Not today. The majority of physicians use 1 or 2 pharmacy platforms that are as advanced as every healthcare pharmacy platform in the

country. In fact, the pharmacy platform the majority of the prescribers in Arizona use is a leader in prescription monitoring programs, and I will be introducing to you guys -- at least in the form of a letter to the CEO of the company -- that they have been instrumental in not just working with prescription drug monitoring programs. They worked with many state enforcement agencies as a leader in fighting opioid abuse and multiple prescriptions. I will be happy to share that data via a letter and conversations in the coming weeks.

On the fourth point, dispensing undermines the mechanisms of drug safety, not just -- there is one conversation about prescription drug monitoring multiple physicians with opioid abuse. The other one is on the payor side mentioned the safety.

We have the same software. We perform the same as our company intends to -- what I'm telling you is two of the largest prescribers in the state are clients of mine, and we are able to use the same formularies as its real-time. I would encourage in front of the panel now, like, to have a conversation with some of the larger payers in the states. We are happy to use the same electronic methods. We are happy to use the same drug utilization review mechanisms, and we can enforce those within our electronic system. What this is really about

-- that addresses three of the four points.

The fourth point to me is what this is about. If we make it about payers and providers and special interest, the majority of the room here is usually special interest on the extremes of both sides. That has to do with enforceable networks or non-enforceable networks. The majority of the price reduction comes mostly from the ability to enforce networks, network contracts and discounts. And I would provide that we could submit the same level of scrutiny for the medical services, for the utilization review, for everything else; but we would like to get paid what the state fee schedule is. And if there is a state fee schedule issued with the pricing, by all means, let's reduce the state fee schedule; and we are happy to have that conversation across the board.

Gale made a great point, he did; but -- when I say "great point," he made a great point on 2 or 3 medications. If you find a subset of thousands of medications and you find 2 or 3 of the outliers, I don't think it -- doesn't do you guys a service to highlight those medications. To that point, I say let's do away with those medications. The ICA adopts the ODG Guidelines, and there are ways to even further adopt more guidelines that would exclude certain drugs from the

formulary. From my perspective, I care about the longevity of the industry. I care about the rights of the providers. At the same time, let's be reasonable. Let's find the bad apples. Let's find the bad drugs.

As it relates to some of the other data points you have heard today thus far, some of the prescribers you have mentioned, you can't state -- you can't quote a ratio of providers versus spend without looking at a medication level. I'm not suggesting more utilization. I'm not suggesting the cost isn't higher. What I am suggesting is the doctors at the top of the list represent thousands of patients in the state where the average provider may have a subset of 1 or 2% more comp at the tops, 70 to 90% more comp; and they have thousands of patients. The devil is in the details, and I don't want to parse through that. This isn't the right forum to grant into those details. I'm open to having further dialogue in the coming weeks. I hope to be part of that process. I'm happy to share with you guys our expertise and our knowledge and hopefully you find reasonable solutions, but I think that's -- make sure I'm not missing a point before I go sit down and my business partner elbows me and says you forgot to say X.

I think I can close there. Thank you guys for your time. Looking forward to continued dialogue on

this front and hope I can be of help to your decisions.

CHAIRMAN SCHULTZ: We look forward to your comments. Thank you. Dr. Randall Prust.

DR. PRUST: Good afternoon. Thank you very much for having me. Appreciate it. I have met earlier with you, and I understand the issue to be more -- not a physician dispensing issue -- but more really a custom compound issue along with non-traditional drug formulas. We use the example of Concentra. I think in their paper they used the example of cyclobenzaprine. Cyclobenzaprine, the traditional strengths were 5 milligrams and 10 milligrams; and somebody came out with a 7.5-milligram tablet; and one of the things -- which was I think it was over two times the cost of the 5s or the 10s. I have never dispensed 7.5 milligrams in my career. I don't know why it is there.

I'm going to suggest a solution to that issue. If you have non-traditional strength medications, you can do, I think, two things. Let's take Tramadol, that is only one strength. The traditional strength is 50 milligrams. I have heard there are 75-milligram pills. That price drops down to 50 milligrams. There is only one dose. That is the price. You can make 100-milligram custom built. Just price it down with the 50-milligram using the fee structures which are exactly the same for

pharmacies and physicians, .85 times AWP. If you have a drug like cyclobenzaprine, 5 milligrams and 10 milligrams, you have one in the middle; take the price of the 10 and the 5; divide it by 2. That is the 7.5 or you can drop it down to 5. I'm thinking that that would be a rather simple solution.

The same could be said with custom compound medications. The reason these are so highly priced, there is an NBC for every medication in a custom compound. Now, I don't use custom compounds, but I know how -- I know what -- how they are priced. So each drug in there has an AWP. You price it out at .85 times AWP. Now you have 6 or 7 drugs that you add up to get to these $3,000 a month type prescriptions which I think is ludicrous. So I think the solution for that would be to -- there are a couple solutions I will suggest.

Number one, allow one AWP in a custom compound med if it meets the ODG criteria. There are compound medications that do meet that criteria. Limit it to one and cap it . Pick a price. I don't know what that price would be. I don't use custom compounded medications. I think that if you -- with some research, it would be relatively easy, I think, to find what a reasonable price might be the average wholesale price for a compound; and that would be the cap. So that,

logically, I think someone who is billing for the compound would probably pick the drug -- one drug with the highest AWP which could still be 700 or 800 for just one prescription, and I think again that would be a solution to those two problems which I think my understanding coming away from the meeting with you, those were the two biggest concerns.

I wanted to say also that the ODG formulary does take care of most of these problems. They have the green drugs, and then the red drugs; and there are rules that we use then to sometimes use red drugs, and those rules are within the ODG, so I don't think we need to deal with that. Our formularies are set. The rules are set. The Commission has adopted it. Save those with repackaged drugs, just what Todd said. We are going to have repackaged drugs, not an issue. We have electronic medical records. Safety is not an issue. I have all the same mechanisms to check. I see every drug the patients are on, when they received the medication, what the drug interactions are. The point was well made, patients don't remember their drugs nearly as well as I do in my electronic medical record.

I think that -- I think that really addresses the issues that I want to discuss, and I hopefully have given you a couple solutions to these

problems; and again, I don't believe it is a physician dispensing issue. You have already dealt with that issue by making the pricing exactly the same for pharmacies and doctors, and I think that they can respond to doctors responsibly; dispense these medications because as they showed, Senate Bill 1010 takes care of literally all the opoid problems. I'm sure there could be some tweaking of it. I think with the self-regulation that we have and you have the Arizona Medical Board, the Arizona Board of Pharmacy and the DEA that looks at doctors to help regulate that field. I think that opioid area is also covered very well. Thank you.

CHAIRMAN SCHULTZ: Thank you, Doctor. We appreciate your input here and also in our stakeholder meetings. Thank you. I know it is a trek up from Tucson. We thank you.

Eileen Muro?

MS. MURO: Good afternoon, Chairman Schultz and Members of the Commission. My name is Eileen Muro. I'm an LPN, and I'm also the practice administrator for Dr. Jeffrey Scott at Palo Brea Pain & Rehab. He couldn't be here because of a telephonic hearing he had.

I would like to read to you the letter that he submitted via the website yesterday in response to the white paper. As a point of introduction, Dr. Scott is a

Board certified physician in physical medicine and rehabilitation since 2002. He has dedicated his entire practice to the treatment of injured workers since that time and has been in practice in Arizona since 2008. Based on this, he is comfortable in providing a voice in the physician community with the regards to the "facts" that were presented in this publication in an effort to provide a brief yet cognizant response. He points out the most salient points of this white paper that in his opinion require feedback.

I will start by pointing out that many statistical facts cited in WCRI statistical data between 2007 and 2011 in states where physician dispensing is common such as Illinois, Georgia, Maryland and Louisiana and notably not Arizona.

Furthermore, a bulk of this paper cites information and statistics that are not applicable in Arizona to either Arizona's manufactured based AWP reimbursement, its enhanced restrictions on physician dispensing of controlled substances and/or its imposition of the ODG medication formulary. These actions, by default, limit the relevancy of several sections of this paper including repackaging, unmanaged prescriptions and physician dispensing and opoid use.

In my opinion the public health impact of

physician dispensing contains hollow arguments in stating that physician dispensing erodes the collective analysis for drug-to-drug interactions and undermines the potential benefits that come with digitization. Not only is that argument antiquated with the advent of EMR, it is simply inaccurate. Physicians are responsible for tracking potential drug-to-drug interactions, not pharmacies, which has been made easier with EMR.

Moreover, many patients choose separate pharmacies for injury versus non-injury related medications. Pharmacies, either accidentally or intentionally, take the path of least resistance for approval and payment of medications which most often is the patient's private insurance regardless of whether the treatment is for a work injury. I have received countless "requires pre-authorization" notices from all the well-known retail pharmacies who then either hold the prescription or wait for someone to get it approved or turn around and run it through the patient's private insurance. Rarely have I received a notice from a PBM or pharmacy regarding potential drug-to-drug interactions even though they may be present. When I have, it typically contains outdated information in which the medication or medications in question have already been discontinued or changed. I cannot recall a specific

example where this process directed either by a PBM or pharmacy has been useful in my practice.

Our dispensing software also has a DUR check. The additional scare tactic provided by this paper is that physician dispensing undercuts the ability of drug monitoring program to efficiently and effectively carry out their function is simply inconsistent with Arizona law as it relates to physician prescribing and dispensing.

Arizona already limits controlled substance physician dispensing; requires CSPMP reporting of what controlled substances are dispensed and mandates review of the CSPMP prior to the controlled substance prescribing or dispensing.

In summary, the analysis provided by the white paper is skewed by the data compiled as most of which appears to be generated by nationwide numbers including states in which physician dispensing is common: Illinois, Georgia, Maryland and Louisiana.

In my opinion many of the conclusions rendered by this publication have limited to no applicability in Arizona given the legislative changes described above. In other words, the statistical axiom of garbage in/garbage out applies. Unfortunately, the Commission did not receive an analysis based solely on the correct measures the State of Arizona already deploys.

It is also unfortunate the undertone of the paper revolves around the cost containment without an impartial discussion of the realities of cost shifting from pharmacies to PBMs.

I would like to conclude by thanking the Industrial Commission for providing an open forum to discuss these issues. It continues to be in the best interest of the entire Arizona workmen's compensation system to identify any specific areas of concern, particularly abuse, and address those concerns as they arise.

As has been learned in other states, painting broad legislative or administrative brush strokes over specific problems drives willing, well-intentioned and ethical workmen's comp providers out of the system.

I want to thank you for the opportunity to speak on his behalf.

CHAIRMAN SCHULTZ: Thank you, and please thank Dr. Scott.

Marc Osborn?

MR. OSBORN: Thank you, Members of the Commission. For the record, my name is Marc Osborn, and I'm here on behalf of PCIA. It is an interesting being in the position -- presenting where half the audience you look at the Commission or the audience, so please don't be

offended if I look at one side or the other. PCI is one of the largest trade association representing workers' comp insurers in the nation. So we have extensive experience in all 50 states. We know the trends. We were one of the organizations that approached the legislature about addressing these issues. I think we wholeheartedly support the comments of both ASIA and CopperPoint in terms of the data that they showed; and when you are looking at this and you talk to the local insurers and self-insurers, they are the ones that see the data every day. And even though there are variations between different states in terms of ODG and the mix of pairs, I think you get a nice trend from looking at the WCRI data in the industry -- I think both on the Commission side and on the industry side and all stakeholders aside -- WCRI is viewed as the gold standard in terms of objective research.

What their finding clearly states is where you have physician dispensing the health outcomes, in many cases are worse than if you use traditional dispensing methods. We believe that the physician dispensing is basically an end-around PBMs and our ability to hold costs down. You know, that pharmaceutical fee schedule is designed to be the ceiling of costs; and I think the state wants to encourage insurers, self-insurers to find the most cost-effective options, especially when they are

beneficial to the patient; and I think by restricting physician dispensing, you can achieve that.

We agree that physician dispensing isn't always convenient for the patient. Going back to the doctor's office time and time again may or may not be convenient; whereas the number of retail pharmacies is far more available. We do agree that there are some reduced patient protections, and one of the things we want to look at is enhancing as part of the fee schedule the requirements of the providers to check databases. I think that is a different discussion, and the same thing with the ODG Guidelines. This is a discussion about physician dispensing cost structures, fee schedules. We are happy to have those dialogues as we fully implement ODG. It is probably not appropriate for this.

If one of these physician dispensers provided medical benefits, the payer community right here supporting it, encouraging it, we don't see that. In terms of our recommendations, we believe that you should limit physician dispensing to no more than 7 days. And that if you are going to dispense, the dispensing activity should happen no later than 7 days after the injury. We are open to discussing the kind of approach of maybe the limit to that, but those are kind of our key limitations; and I will be happy to answer any questions.

CHAIRMAN SCHULTZ: We are holding questions until the end. Thank you for your comments.

Deb Baker?

MS. BAKER: Hello, Mr. Chairman, Commissioners, Director and Counsels, thank you for giving me the opportunity to speak. So many others have stole my thunder.

CHAIRMAN SCHULTZ: Please introduce yourself.

MS. BAKER: I'm Debbie Baker. I'm the work comp director for the Valley Schools Workers' Compensation Group.

I completely agree with CopperPoint, CorVel, ASIA, PCI and PCG. I think they have all done a fabulous job addressing the very salient points. One thing I would like to say is, yes, we have DEA; and we have regulations and all this for opioids; and I could stand here and name doctors that today are prescribing opioids when they are getting drug tests back with inconsistent results showing that the injured worker is not taking opioids. They are taking methamphetamine or other illicit drugs, yet the doctors continue to prescribe opioids every 30 days.

So, yes, we have some things in place; and I think that's wonderful, but I think we are taking baby steps. And while we are taking those baby steps, addicts

are being created; and it's up to us as claims professionals to step in and use the tools of our trade to prevent the addiction. So speaking on behalf of Valley Schools only, I'm totally against physicians dispensing compounds and narcotics of any kind. I do agree. There should be a formulary for physician dispensing if that's going to be allowed; and I also feel that, yes, there should be a time limit, maximum 7 days.

It has been said before, there are pharmacies everywhere. PBMs do a wonderful job. There is not a delay in medications getting approved. It is all done electronically. They get approved. The injured worker gets their medications, and they leave and they can go to any pharmacy they choose. That's all I have to say. Thank you for listening.

CHAIRMAN SCHULTZ: Thank you. Is there anyone else who wishes to speak at this time? Trevor, how do we connect to the folks on the phone? Does anyone on the phone have -- wish to make any statements?

(Silence.)

CHAIRMAN SCHULTZ: Thank you. Now, we will move to -- did I hear a response?

ELLEN (via phone): Mr. Chairman, this is Ellen (inaudible) representing the American Insurance Association, and I'm so sorry I cannot be there today.

I'm on the East Coast, and I let Jackie Kurth know that I will be submitting comments by September; and we appreciate the opportunity to weigh in that way. So thank you very much.

CHAIRMAN SCHULTZ: Thank you, Ellen. We want to create an opportunity for all participants to ask questions. If you have questions concerning any of the materials, any of the speakers, please come forward to the podium and introduce yourself and state who you are representing and proceed with the questions. Crickets. I'm hearing crickets, and that's just fine.

I want to thank you all for coming today. I know you have to take time out of your schedules to do this, but the Commission very, very, very much appreciates input from stakeholders as we go through our deliberations and decide whether we are going to adopt any new rules, regulations or parts to the pharmaceutical fee schedule.

So this will conclude the public hearing concerning medications dispensed in settings that are not accessible to the general public. We appreciate your attendance and participation. As a reminder, although the oral proceeding has concluded, written comments will be accepted through the close of business on September 13th, 2018. Written comments may be submitted to Jackie Kurth, Manager of the Medical Resource Office; and her contact

information is available on the Commission's web page, AZCIA.gov. Thank you. We will adjourn temporarily and move upstairs to conduct the rest of our Commission meeting. Anyone who wishes to attend the rest of the meeting can join us upstairs. Thank you all for coming.

(Proceedings concluded at 2:30 p.m.)

STATE OF ARIZONA)
)
COUNTY OF MARICOPA)

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